ARMS GUIDE (TECHNIQUES)
AVIATION MEDICINE

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The FORSCOM ARMS Guide is neither a regulation or regulatory in nature. The Guide questions are based on requirements stated in regulations and various other written directives. The Guide is simply a tool that can be used to address those requirements. The applicability codes were developed to facilitate and enhance the use of the ARMS Guide. Applicability codes are intended to assist the user in determining which questions apply to typical Army organizations. As with all attempts to establish absolute rules, there are special conditions and unique situational variations. If you have a question as to applicability of a question to your organization, contact the FORSCOM functional area lead listed on this AKO web site https://www.us.army.mil/suite/page/592726. In all cases applicability of requirements will be determined by the ARMS Team, through direct coordination with the organization, and application of current regulations and directives.

This Guide is applicable to the Active Army, Army Reserve and Army National Guard Aviation and ATS Units.

Applicability Guide: (AC) Aviation Company/ Troop, (AF) Airfield, (AM) Aviation Maintenance Company/Aviation Maintenance Troop, (AS) Aviation Support Company/Aviation Support Troop, (AT) Air Traffic Services, (BN) Battalion/Squadron, (CO) Contractor, (DE) Detachments, (FS) Forward Support Company, Forward Support Troop, (IO) Installation Only ATS, (OS) Operational Support Airlift, (OT) Operational Support Airlift Tactical, (OV) Operational Support Airlift Validator, (SB) Aviation Support Battalion (ASB), (SF) Aviation Support Facility/Army Aviation Support Facility (ASF/AASF), (TO) Tactical Only ATS, (UA) Unmanned Aircraft Systems

A-COMMAND FACTORS
QUESTION

1.00 **AC AF AS AT BN DE SB SF**

Are corrective actions taken on deficiencies noted on previous evaluations of the aviation medicine program? [AR 1-201, para 2-2e]

REFERENCE TEXT

AR 1-201, para 2-2e. Followed up. Inspections expend valuable resources and are not complete unless the inspecting unit or agency develops and executes a follow-up inspection or plan to ensure the implementation of corrective actions. Likewise, the inspected unit must develop and execute a corrective-action plan that fixes those problem areas identified during an inspection. Follow-up actions can include re-inspections, telephone calls (or visits) to units or proponents to check on the progress of corrective actions, or a request for a formal response from a unit or proponent that attests to the completion of the corrective action. To reduce the administrative burden on inspected units, a formal response to inspection reports is optional unless specifically requested.

EVAL METH:

Identify discrepancies rated as UNSAT during the last ARMS or previous AAPS. Determine if the last discrepancies are currently corrected. Ensure at least 70% of past ARMS discrepancies are currently rated satisfactory. Have them start a baseline with current inspection. Seek FORCOM guidance if unit recently activated or reflagged.

2.00 **AC BN SB**

Are the authorized number of flight surgeons assigned (authorized and required) IAW AR 616-110, para 11a, and 11 b. If not, is the shortage listed on the USR? [AR 616-110, para 11a, 11b; AR 220-1, para 4-5d(2)]

REFERENCE TEXT

AR 616-110, para 11a, b. The role of Army Aviation Medicine is to support Army aviation's mission. Flight surgeon requirements are determined by the number of aviation personnel supported, with the ratio of 250 aviation personnel per one flight surgeon generally not to be exceeded. Aviation personnel include individuals on operational and non-operational status within the area supported by the flight surgeon. Variables such as size, number, and location of units supported, frequency of deployment, mission requirements, and area support requirements may increase the number of flight surgeons required to conduct the Aviation Medicine Program. Questionable cases will be submitted for review by TSG (HSXY-AER) or the Chief, National Guard Bureau (ARNG-OAC). a. Flight surgeons are required in the table of organization and equipment (TOE) of aviation battalions or squadrons and larger units to provide advice on medical matters to the commanders and to provide medical treatment for assigned unit personnel. b. Flight surgeons, SSI 61N, are required in tables of distribution and allowances (TDA) as follows: (1) Medical section of headquarters elements at installations which provide medical support for Army aviation operations, regardless of size. (2) Staff sections of major command headquarters in the position of aviation medicine consultant. (3) Faculty positions at selected U.S. Army schools. (4) Staff positions at selected U.S. Army medical research and development activities. (5) Staff positions in selected Department of Army supervised activities. (6) Staff positions in the Office of The Surgeon General (TSG), Department of the Army. (7) Clinical positions in medical treatment facilities for the purpose of providing aero medical consultation and/or aviation medicine support. AR 220-1, para 4-5d(2) If shortages of SQIs and ASIs are degrading readiness, remarks are required in the 2ADDSKILL set of the report.

EVAL METH:

Ask the S1 on day one for this info. Review the unit manning roster and MTOE to determine if authorized Flight Surgeons are assigned. If they are not, ensure that the shortage is reflected in the unit manning roster and in the unit status report. If units are not authorized a FS, this question is not applicable and question 3.00 below is. If unit is not assigned a FS and APA, check to see if the shortage is listed in the unit's (Battalion/Brigade) Top 5 shortages. If not, recommend to add the shortage to the Top 5 USR Personnel Shortage list.

3.00 **AC AF AS AT BN DE OS SB SF UA**

In units without an authorized or assigned flight surgeon, does the local medical treatment facility (MTF) Commander, and/or the Regional Medical Command Surgeon (ACOM, USARC or State Surgeon, ARNG) provide personnel and equipment to ensure implementation of the Aviation Medicine Program at the local level? [AR 40-3,para 3-2d, 3-2j-l; DA Pam 385-90,para 1-4p; AR 616-110, para 12b]

REFERENCE TEXT

AR 40-3,para 3-2d. Regional Medical Command (RMC) commanders will; (1) Ensure implementation of the AVMED Program. (2) Assign a residency-trained specialist in aerospace medicine as RMC Chief, AVMED. When a specialist is not available, an experienced flight surgeon (FS) will be temporarily assigned until a specialist is made available. *e.* The RMC Chief, AVMED will oversee the RMC AVMED Program and act as the RMC advisor for aeromedical policies and issues such as FS deployments, aeromedical evacuation policy, and regional review and disposition of flight physicals AR 40-3,para 3-2j-l. The installation medical authority (MTF commander) of installations hosting both Active Army and Reserve Component (RC) aviation assets will: (1) Establish, supervise, administer, and support the AVMED Program. (2) Appoint a senior installation FS or aeromedical physician assistant as Chief, AVMED. (3) Ensure that the AVMED Program is included in the MTF's specific organizational performance improvement (PI) structure. *k.* The chief of AVMED will oversee the installation AVMED Program and coordinate the efforts of the aviation medicine team consisting of aviation psychology, dentistry, and optometry. *l.* Unit-level FS responsibilities are described in paragraphs 3–5 and 3–6. DA Pam 385-90, para 1-4p. Flight surgeon. The flight surgeon assists and advises the command in all aviation medical matters. In remote areas where a flight surgeon is not assigned or readily available, local support will be provided by the servicing medical department activity (MEDDAC) to best accomplish these duties. The flight surgeon should: (1) Maintain liaison within the command to implement the aviation medicine program. (2) Take part in, and observe, flight operations to monitor the interactions of crewmembers, aircraft, and environment. The flight surgeon exerts maximum effort in observing the flying ability and characteristics of each assigned aviator at least annually. (3) Serve as a member of aircraft accident investigations board, when directed. (4) Serve as a member of flight evaluation boards, when directed. (5) Ensure that the medical portion of the pre-accident plan is adequate. (6) Monitor the physical and mental health of aviation personnel, including alcohol, tobacco, dietary supplements, and self-medication problems (See AR 40–8). (7) Advise the commander on crew-endurance issues. (8) Maintain aviation medical records on flight personnel, assist the unit in providing annual occupational health and safety screening for non-crewmember personnel, and ensure that DA Form 4186 (Medical Recommendation for Flying Duty) prepared on flight personnel is accurate and complete prior to being sent to the unit commander for approval. (9) Monitor the survival and physiological training of aviation crewmembers and provide medical support in accordance with applicable Army regulations. (10) Medically clear crewmembers for further flight duty after aircraft accidents in accordance with applicable Army regulations. (11) Make recommendations to the Commander, USACRC, for improvement of human factors compatibility, crashworthiness, aviation life-support equipment, and survival features of aircraft. (12) Take part in aviation safety meetings to educate aviation crewmembers on the aeromedical aspects of flight. (13) Monitor the aviation life support equipment (ALSE) program. (14) Assist in, and advise on, the hearing and occupational vision program. (15) Ensure command consideration of preventive and occupational medicine aspects of all plans, operations, training, and security missions. AR 616-110 para 12b. Other duties will not jeopardize the primary aviation medicine effort. Flight surgeons should not be utilized in other medical activities when fulltime application to aviation medicine is required to meet local aviation medicine requirements. (This is not an exemption for all flight surgeons from other medical activities.)

EVAL METH:

Check to see if aviation medicine program requirements are being met for units/facilities without an assigned flight surgeon. Verify that each one of the (15) Flight Surgeon responsibilities listed in DA PAM 385-90,paragraph 1-4p is being satisfied. At least 70% of the requirements listed in DA PAM 385-90 paragraph 1-4p must be satisfied to receive a SAT for this question. Although not mandatory, check to see if there is an existing Memorandum of Understanding/Agreement between supported aviation unit and installation medical treatment facility describing Flight Surgeon assistance. MOUs/MOAs reduce confusion and allow situation awareness / understanding between the two organizations.

4.00 **AC AF AS BN DE OS SB SF**

Has the flight surgeon or aeromedical physician assistant established an Aviation Medicine Standing Operating Procedures (SOP) that describes all necessary operational, safety and health requirements of the Aviation Medicine Program? [AR 385-10, para 18-5a,c DA PAM 385-90, para 2-12, FM 4-02, para3-2c]

REFERENCE TEXT

AR 385-10, Para 18-5a. Standing operating procedures- *a.* Standing operating procedures will be developed for all hazardous operations in accordance with the requirements of DA Pam 385–10 and provide supervisors and operators the level of detail necessary to execute the task or operation in an efficient, effective, and safe manner. Written standards (for example, work plans, internal operating plans, operating manuals, work instructions, FMs, and so forth) may be substituted for SOPs when they provide the level of detail necessary to execute the task or operation in an efficient, effective and safe manner. DA PAM 385-90, para2-12 Standing operating procedures- Commanders should ensure that an SOP is developed for all unit functional areas and for all aviation operations executed in the command. The SOP may, where applicable, be consolidated at the battalion/squadron or regiment/brigade/group level. The systematic risk management process should be integrated in all unit operational procedures. Command approved risk-control options should be integrated into the SOP as task performance standards. FM 4-02, 3-2c. The duties and responsibilities of command surgeons may include, but are not limited to—Developing policies, protocols, and procedures pertaining to the medical and dental treatment of sick, injured, and wounded personnel. These policies, protocols, and procedures will be in consonance with applicable regulations, directives, and instructions; higher headquarters policies; standing operating procedures (SOPs); applicable STANAGs and QSTAGs; memorandums of understanding (MOU) or agreement (MOA); Status of Forces Agreements (SOFAs); and the DEPMEDS Administrative Procedures, Clinical and Support Guidelines, and Patient Treatment Briefs (Appendix A).

EVAL METH:

Evaluator will review the Aviation Medicine SOP for Non-clinical and Clinical responsibilities. Evaluate if the AVMED SOP is available to all supported crew members to read. ie. GSOP, TACSOP, Facility SOP, Unit SOP, State AVMED SOP.

5.00 **AC AF AS BN DE OS SB SF**

Are the supporting flight surgeon and/or aeromedical physician assistant on flight status with valid orders issued by the appropriate agency? [AR 600-105, paras 3-9a, 3-9b(1-3), 3-11a-c; AR 600-106, para 2-2a(1), (3)]

REFERENCE TEXT

AR 600-105, Para 3–9a. Operational flying duty for flight surgeons a. Flight surgeons are considered on operational flying duty when placed on aviation service orders by TSG, CDR, ARPERCEN or CNGB. This duty entitles them to monthly Aviation Career Incentive Pay (ACIP). AR 600-105, para 3-9b(1-3). Duties include the following - (1) Formal aviation medicine training leading to the award of an aeronautical rating. (2) Formal aerospace medicine residency training leading to certification in aerospace medicine. (3) An assignment to a position or location determined by TSG; CDR, ARPERCEN; or CNGB that requires the flight surgeon to conduct a local aviation medicine program. (4) Any assignment for an aerospace medicine specialist, primary AOC 61N9A/B/C, provided the person remains actively involved in an aviation medicine program. AR 600-105, para 3-11a-c: a. Only TSG; CDR, ARPERCEN (effective 1 Oct 94); or CNGB will issue orders initiating or terminating flying duty and entitlement for monthly ACIP for flight surgeons. AR 310-10, format 331, will be used for all orders. Entitlement to ACIP for periods of travel, TDY, and leave will be determined according to paragraph 3-9, so long as semi-annual and annual flight surgeon flying minimums are met (DODPM, part two). Orders for flight surgeons will normally qualify them for aviation service and will, in addition, indicate whether or not they are being assigned to operational flying duty (duty AOC 61N). b. Normally, all Medical Corps officers who have been awarded AOC 61N, and who meet the requirements in paragraph 3-9, will be placed on flying duty orders. Officers in other positions, not qualifying under paragraph 3-9, are authorized to practice aviation medicine on an occasional or short term basis without being on orders. Those serving more than 2 weeks as a substitute for the regular flight surgeon will be placed on temporary flight status. c. Once entered into aviation service, flight surgeons continue in aviation service regardless of duty. However, TSG; CDR, ARPERCEN; or CNGB will issue assignment instructions in the orders that terminate or continue operational flying duty and entitlement to ACIP or upon reassignment to non-operational flying duty. AR 600-106, para 2-2a (1) For the soldiers who meet the requirements of paragraphs 2-3, 2-4, and 2-5: Active Army major command (MACOM) commanding generals, commanders of continental United States (CONUS) installations, and the state Adjutants General. Due to wide dispersion of aviation units and finance office support, outside continental United States (OCONUS) MACOM commanders may further delegate authority to issue flight status orders to no lower than the battalion commander. (3) For Aeromedical Physician Assistants: The Surgeon General (DASG-PTZ), 5111 Leesburg Pike, Falls Church, VA 22041 or for ARNGUS – State Adjutant General.

EVAL METH:

Check for current flight status orders in the supporting Flight Surgeon's or APA's IFRF.

6.00 **AC AF AS BN DE OS SB SF**

Do the flight surgeon and/or aeromedical physician assistant meet the minimum flying hour requirements? [AR 600-105, para 3-10a-c]

REFERENCE TEXT

AR 600-105, para 3–10, a. Flight surgeons annual minimum flying hours a. Flight surgeons assigned to flying duty must be credited a minimum of 4 hours per month in any military aircraft for active duty and 2 hours per month for RC to qualify for monthly ACIP (DODPM, part two). Rules pertaining to the banking of hours apply. Table 3–4 defines minimum hourly requirements for flight surgeons. b. Semiannual and annual minimum requirements will be reduced proportionately for those who begin or end flying during a certain flying year. c. Local unit commanders whose mission includes little or no night flying are authorized to waive night hour requirements for their assigned or attached flight surgeons. Questionable cases may be referred to TSG; CDR, ARPERCEN; or CNGB for determination as applicable. In no case will a waiver be given for the minimum flying

requirements for pay required by DODPM.

EVAL METH:

Check flight records to determine if assigned flight medical personnel met minimum requirements. Table 3-4 in AR 600-105 has not been updated to reflect flight surgeons and APAs require only 48 hours annually for active duty and not the 60 as shown in the table. The Reserves and National Guard require 24 hours annually. The annual night hours is correct, and it is part of the total annual hours as above.

7.00 **AC AF AS BN DE OS SB SF**

Do the flight surgeon and/or aeromedical physician assistant participate as an air crewmember in each type of aircraft assigned to supported units? [AR 40-3, para 3-6f (6); AR 600-105,
para 3-10d]

REFERENCE TEXT

AR 40-3, para 3-6f(6) Participate in an operational capacity as an air crewmember in flight in each type of aircraft assigned to supported units. An FS's operational capacity will include observing flight crewmembers, monitoring patients, and so forth. Flight will be in all flight environments—including emergency procedures—and mission profiles (for example, nap of the earth, night vision goggles, and so on.) according to AR 95–1 and AR 600–105. Flight simulators may be used to broaden flight surgeon exposure to various flight environments and mission profiles. The purpose of this simulator time is to ensure that FSs understand the mission profiles and stresses of the aviators that they support. Flight simulator time does not count toward meeting the aviation career incentive pay flying hour requirement. AR 600-105, para 3-10d. Flight Surgeons are considered essential aircrew and are expected to fly- (1) primarily with the unit(s) they support. (2) In all types of military aircraft and mission profiles in their units. (3) May log up to 12 hours (Active Army) or 6 hours (ARNGUS and USAR) of SFTS time toward accomplishment of annual flying hour requirements. SFTS may not be counted toward the accomplishment of flight pay requirements.

EVAL METH:

Check for flight surgeon participation as a crewmember in all types of military aircraft and mission profiles in their units or in units that they support. Coordinate with FORCOM ARMS Operations Inspector to verify completion of this task.

8.00 **AC AF AS BN DE OS SB SF**

Are the flight surgeon and/or aeromedical physician assistant incorporated into the local unit Reading File? [AR 95-1, para 4-4]

REFERENCE TEXT

AR 95-1, para 4–4. Aircrew information reading files: Aviation units will establish and maintain aircrew training and information reading files per FM 3-04.300 and TC 1–210. Assigned aircrew personnel will read and remain familiar with these files.

EVAL METH:

Check for evidence that the assigned medical personnel are included into reading files. The FS must be incorporated into a local reading file. For example, if a FS is assigned to and primarily flies with the 214th AVN BN, but also supports other units at the local airfield or AASF, the FS must at a minimum be integrated into the 214th AVN BN's reading file. If that FS also flies with units at another airfield or AASF, the FS must be integrated into those reading files in addition to the 214th AVN BN's reading file.

9.00 **AC AF AS AT BN DE OS SB SF UA**

Do Individual Flight Record Folders (or ATS Controller Records) contain the required DA Form 4186 (medical clearance for flying or medical restriction from flying) and are they completed correctly? [AR 40-501, para 6-11d;]

REFERENCE TEXT

AR 40-501, para 6-11d. Each item of the DA Form 4186 will be completed as directed by the Commander, USAAMC. (See ATB, DA Form 4186.) Three copies of the DA Form 4186 will be completed. Copy 1 is placed in the outpatient medical record. Copy 2 is forwarded to the examinee's unit commander who signs and forwards it to the flight operations officer for inclusion in the flight records (AR 95–1 and FM 3-04.300). Copy 3 is given to the examinee.

EVAL METH:

Check IFRFs for assigned crew members. Verify that all required DA Forms 4186 are maintained in the IFRF and that all blocks are filled out appropriately.

10.00 **AC AF AS AT BN DE OS SB SF UA**

Do individual Flight Records contain applicable medical waiver approval letters, and are the waivers in the acceptable abbreviated format? [AR 40-501, para 6-10g; FM 3-04.300, para6-15]

REFERENCE TEXT

AR 40-501, para 6-10g. Disposal of documentation. Waiver and suspension recommendation and approval letters will be filed in the individual health record and flight record. When available, the AERO Abbreviated Waiver Letter shall be utilized for the individual flight record folder (IFRF) for Health Insurance Portability and Accountability Act (HIPAA) compliance of protected health information. FM 3-04.300, para 6-15. Recent guidance for the protection of health information was published under the Health Insurance Portability and Accountability Act (HIPAA). This act requires the safeguard and security of medical information. The retention of medical waivers with personal health information in the IFRF

is no longer acceptable. An abbreviated waiver memorandum summarizing the medical waiver, periods of retention, and actions recommended by the medical authority should be filed instead. This memorandum can be obtained from the Flight Surgeon.

EVAL METH:

Check IFRF for applicable waiver approval letters. Check to ensure IFRF waiver documentation is not in violation of HIPAA. IFRF waiver approval memorandums are obtained from the Flight Surgeon/AERO. Recommend maintaining a current waivers roster. NOTE: Crewmembers with missing waivers granted prior to 2003 require the supporting Flight Surgeon or Aeromedical Physician Assistant (APA) to verify the waiver authority dates in AERO. Then the supporting Flight Surgeon or APA can create a memorandum for record in the current abbreviated waivers format verifying the waiver and a copy of this memo will be posted to the medical section of the individual flight record folders (IFRF). Waivers granted after 2003 can be obtained through AERO, and then posted to the IFRF.

11.00 **AC AF AS AT BN DE OS SB SF UA**

Are extensions granted for flight physicals prior to the expiration date of the current physical? [AR 40-501, para 6-11i]

REFERENCE TEXT

AR 40-501, para 6-11i. The validity period of the current FDME/FDHS (see para 6-8) may be extended for a period of 1 calendar month beyond the birth month on the DA Form 4186. After expiration of this extension, the aircrew member or ATC must complete the FDME/FDHS and be medically qualified or be— (1) Administratively restricted from flying duties if no aeromedical DQ exists and be considered for a non–medical DQ and FEB (AR 600–105). (2) Medically restricted from flying duties if an aeromedical DQ exists. In some cases, temporary flying duties may be recommended on DA Form 4186. (See also f, above, and para 6–12 through 6–20.)

EVAL METH:

Check extensions for correct dates. Ensure extensions are granted before the end of the birth month. Any extensions requested and granted in the month after the birth month are not valid. The effective date of the extension is the day it was requested. Ensure that extensions granted under the 120 day rule are correctly documented per the 20 October 2005 Surgeon General's policy letter concerning Operational Aeromedical Administration.

12.00 **AC AF AS AT BN DE OS SB SF UA**

Are crewmembers or ATC personnel performing aviation duties with expired physicals or extensions? [AR 95-1, para 2-1b; AR 40-501, para 6-11i; AR 600-105, para 6-1c(2); AR 600-106, para 2-7c(2); FM3-04.300,para,6-32]

REFERENCE TEXT

AR 95-1, para 2-1b. All Army aviators who are in aviation service per AR 600-105 must meet the annual physical requirements of AR 40-501 regardless of assignment. AR 40-501, 6-11i.The validity period of the current FDME/FDHS (see para 6-8) may be extended for a period of 1 calendar month beyond the birth month on the DA Form 4186. After expiration of this extension, the aircrew member or ATC must complete the FDME/FDHS and be medically qualified or be—(1) Administratively restricted from flying duties if no aeromedical DQ exists and be considered for a non–medical DQ and FEB (AR 600–105). (2) Medically restricted from flying duties if an aeromedical DQ exists. In some cases, temporary flying duties may be recommended on DA Form 4186. (See also f, above, and paras 6-12 through 6-20.) AR 600-105, 6-1c(2). Failure to maintain medical certification. All officers, regardless of component or whether or not assigned to operational flying duty assignments must maintain medical certification for flying duty through timely physical examinations (AR 40–501). If the certification expires, the officer is unfit until medically requalified or a temporary medical extension is provided. Aviation service is suspended effective the day following the last day of his or her birth month. In cases where temporary medical extension has been provided, aviation service is suspended on the first day following the last day of the extension. The immediate commander will temporarily suspend the officer from flying duty. AR 600-106, 2-7c(2). Soldiers who have not had a current valid medical examination as stated in AR 40–501 will be automatically suspended from flying status. The suspension will be effective on the date their medical examination expires. Commanders will notify the servicing Finance and Accounting Office when nonrated Army aviation personnel have been suspended from flying status. FM3-04.300, para,6-32 Individuals who do not have a current flight physical, or a 1-calendar month extension to complete their annual medical examination documented on DA Form 4186, will be suspended from flying status until medical clearance is given. Commanders will notify the servicing finance and accounting office when personnel are suspended from flight duties.

EVAL METH:

Look for expired FDMEs in the Health Records and in AERO. Use the DA Form 2408-12 print out from Flight Operations to determine if crewmembers performed flight duties while not medically qualified. Finding one expired physical or extension constitutes an unsatisfactory rating.

13.00 **AC AF AS BN DE OS SB SF**

Are non-operational aviators completing annual flight physicals? [AR 600-105, para 3-1c; AR 40-501, para 6-11c]

REFERENCE TEXT

AR 600-105, 3-1c. All aviators and flight surgeons, whether or not assigned to operational flying duty positions, must meet class 2 medical fitness standards for aviators and class 2F medical fitness standards for flight surgeons for flying duty (AR 40–501), and be issued a medical clearance on DA Form 4186, Medical Recommendation for Flying Duty. Flight surgeons who resigned from aviation service (AR 616–110) or who have been terminated from aviation service by TSG; CDR, ARPERCEN; or CNGB, are not required to maintain class 2F medical certification. AR 40-501, 6-11c. Rated aviators not performing operational flying duties are required to complete an annual FDME/FDHS with issuance of DA

Form 4186 (AR 600–105).

EVAL METH:

Check to ensure all non-operational aviators, who's IFRFs are maintained by the inspected unit, maintain a current FMDE in the Health Record and DA Form 4186 (up-slip) in the IFRFs and the HREC. DA Form 759 closeout (rated aviator) Block 12 in the IFRF indicates if individual is in an operational flying position (yes or no). If yes, "YES", and the date assigned to that position is place in Block 12.

14.00 **AC AF AS AT BN CO DE OS SB SF**

Are Department of the Army Civilian (DAC) pilots, contract pilots, civilian non-rated crewmembers or noncrew members, contract non-rated crewmembers and non-crewmembers, civilian Air Traffic Control (ATC) personnel, and Wage Grade 11 (WG-11) personnel maintaining valid Army Flying Duty Medical Examinations (FMDEs) or Federal Aviation Administration (FAA) Medical Certificate? [AR 40-501, paras 4-2b(3), (4), 4-2d, 4-2e, 4-31a(1-3), 4-33a(1), (3)]

REFERENCE TEXT

AR 40-501, 4–2b Class 2 standards apply to: (3) The DAC pilots. (4) Contractor pilots will have the option, as specified in the contract, of maintaining either a current Federal Aviation Administration (FAA) Class 2 Medical Certificate or an Army Class 2 FDME. Army Aeromedical Surveillance is an integral part of Army Aviation Risk Management. Therefore, contractor aircrew who opt for the FAA certificates must submit a copy of the FAA certificate, with any applicable Statement of Demonstrated Ability (SODA) or FAA waiver, to USAAMA and give permission to the FAA to provide their medical information to the U.S. Army Aeromedical Activity in order to continue population based medical surveillance and ensure risks to flight safety are minimized. The aforementioned information will be mailed to USAAMA (MCXY–AER), Building 301, Dustoff Street, Fort Rucker, AL 36362; or faxed to commercial 334–255–7030 or x7060 (DSN 558); or scanned and emailed to aama@amedd.army.mil. AR 40-501, para 4-2d. Class 3 standards apply to non-rated crewmembers (AR 600–106). Soldiers and civilians ordered by a competent authority to participate in regular flights in Army aircraft, but who do not operate aircraft flight controls. These include crew chiefs, aviation maintenance technicians, aerial observers, gunners; unmanned aircraft system operators (UASO), nonrated (AR 600–106) medical personnel selected for aeromedical training, such as flight medical aidmen, psychologists, and others (see para 4–32). Army civilian contractor non-rated crewmembers will have the option, similar to paragraph 4-2b(4), of maintaining either a FAA Class 3 Medical Certificate or DA Form 4186. AR40-501, para4-2e Class 4 standards apply to military ATCs. Civilian ATCs are required to meet Class IV OPM standards (see ATB, ATC Civilian Standards, DAC and contract). AR 40-501, para 4-31a (1-2).The following references apply as noted. (1) 5 CFR Part 339, Office of Personnel Management, applies to DA civilians. (2) AR 95-20/AFJI 10-220/NAVAIRINST 3710.1E/DCMA INST 8210.1 applies to contract civilian aircrew members who fly in aircraft owned or leased by DOD. (3) 14 CFR Part 61 and 14 CFR Part 67, Federal Aviation Administration, do not apply since Army civilian aircrew members fly public use aircraft. The agency that owns or operates public use aircraft is responsible for the medical certification of aircrew flying those aircraft. AR 40-501, para 4-33a(1-2). DAC and DA contract civilian ATCs. (1) Medical qualification requirements for Department or the Army civilian Air Traffic Controllers are outlined in Office of Personnel Management Operating Manual: Qualification Standards for General Schedule Positions, GS-2152: Air Traffic Control Series, in accordance with section 339.202, Title 5, Code of Federal Regulations. (2) DA contract civilian ATCs may be required by their contractor employer to maintain a Class II Federal Aviation Administration (FAA) medical certification; but this certification in not required by DA or FAA for contract ATCs to control air traffic in DOD facilities (14 CFR 65.31, 33). The initial and subsequent determination of medical fitness for ATC duties are made as outlined in this regulation. The contract will state that DA contract ATCs will meet the same medical qualification requirements as those for DA civilians set forth in (1) above.

EVAL METH:

Check to ensure all applicable personnel maintain a current FDME through DA Forms 4186 in the IFRF, FDMEs in the Health Records, or AERO. In the case of contract personnel, ensure that the COR verifies that personnel required to receive Army FDMEs are receiving them. Contractors who complete a FAA Medical Examination will have a FAA Form 8500-9 and not a DA Form 4186.

15.00 **AC AF AS AT BN DE OS SB SF**

Does the flight surgeon, aeromedical physician assistant or unit track FDME/FDHSs via AERO from initiation through posted in the Health Record, with a final disposition from USAAMA? [AR 40-501, para 6-10f]

REFERENCE TEXT

AR 40-501, para 6-10f. Tracking. The flight surgeon or aviation unit will track FDMEs/FDHSs via AERO from initiation until posted in the health record with a final disposition by USAAMA. If disqualified, the flight surgeon and aviation unit will take action as per AR 600–105 and AR 600-106.

EVAL METH:

Check the unit or FS office to ensure AERO accounts are established for FDME/FDHS tracking, submission, review and disposition. Check procedures (SOP or other documentation of procedures) to ensure FDME/FDHSs are tracked. Procedures must ensure that the medical status of individual crewmembers is tracked by the FS or unit. These procedures must ensure that FDME/FDHSs are tracked to and from AAMA (for class 1, 2, 3 and 4 qualification) and with final AAMA stamped copy of the DD Form 2808/DA Form 4497 into the Health Records. Verify effectiveness of procedures by checking Health Records for the filing of AAMA qualified (stamped) FDMEs and the Aeromedical Electronic Records Office (AERO) for AAMA qualification of the FDMEs.

16.00 **AC AF AS AT BN DE OS SB SF**

Are procedures in place whereby air crewmembers are automatically grounded when treated in an emergency center or specialty clinic? [AR 40-3, para 3-5d; AR 40-8, para 4-b; AR 40-501, 6-11b(5) thru (8)]

REFERENCE TEXT

AR 40-3, para 3-5d. Aeromedical consultation. The FS will— (1) Ensure that an on-call service for aeromedical emergencies and aeromedical evacuation consultations is in place during all hours of flight operations. (2) Interview newly assigned aviation personnel and review their medical records before granting a medical clearance to fly. (3) Establish procedures whereby air crewmembers are automatically grounded when treated in the emergency center (EC) or specialty clinic. Protocols will then require grounded air crewmembers to report to the FS as soon as reasonably possible. (4) Medically clear air crewmembers for further flight duty following temporary medical disqualification or aircraftmishap.(5) Ensure timely evaluation of aviation personnel who are medically disqualified. AR 40-8, 4b. Aircrew members will immediately inform their flight surgeon or APA when they have participated in activities or received treatment for which flying restrictions may be appropriate. This includes exposure to any exogenous factors listed in this regulation as well as any treatment or procedure performed by a non-flight surgeon or APA and includes, but is not limited to, the following: (1) Any medical or dental procedure requiring use of medication after the treatment. (2) Any medical or dental procedure requiring use of any type of anesthesia or sedation. (3) Treatment by mental health professionals, including but not limited to psychological, social, psychiatric, alcohol, or substance abuse counseling. (4) Any chiropractic or osteopathic manipulative treatment. (5) Any treatment given by a homeopath, naturopath, herbalist, or practitioner of other types of alternative medicine. (6) Any emergency room or urgent care visits. AR 40-501, 6-11b, 5, 6, 7, 8. b. DA Form 4186 will be completed— (5) When admitted to and discharged from any medical or dental treatment facility (inpatient or outpatient, military or civilian), sick in quarters, interviewed for or entered into a drug/alcohol treatment program, or when treated by a health care professional who is not a military FS/APA/AMNP/AME or otherwise authorized to issue a DA Form 4186. (6) When treated as an outpatient for conditions or with drugs that are disqualifying for aviation duties; and upon return to flight duties after such treatment and recovery. (7) Upon return to flight status after termination of temporary medical suspension, issuance of waiver for aviation service, or requalification after medical or nonmedical termination of aviation service. (8) Other occasions as required by the FS/APA/AMNP/AME or qualified aeromedical health care provider.

EVAL METH:

Check for written procedures to automatically ground crewmembers when they receive emergency treatment. Verify existence of procedures by reviewing SOPs, memorandums for record, reading files, or aeromedical classes concerning non-flight surgeon treatment.

17.00 **AC AF AS BN DE OS SB SF**

Does the Flight Surgeon ensure that the medical portion of the pre-accident plan is adequate? [DA PAM 385-90, para 1-4p(5), 2-9c(1); AR 40-3, para 3-6.f(3); AR 40-21, para, 3c]

REFERENCE TEXT

DA PAM 385-90, 1-4p(5). Flight surgeon. The flight surgeon assists and advises the command in all aviation medical matters. In remote areas where a flight surgeon is not assigned or readily available, local support will be provided by the servicing medical department activity (MEDDAC) to best accomplish these duties. The flight surgeon should: (5) Ensure that the medical portion of the pre-accident plan is adequate. DA PAM 385-90, para 2-9c(1). Pre-accident plans will be systematically rehearsed and reviewed for adequacy quarterly (at a minimum). Rehearsal of plans will be coordinated in accordance with AR 420–90. AR 40-3 para 3-6.f (3), Participate in aircraft mishap exercises and observe the effectiveness of response, equipment, and communication of fire rescue, air ambulance, and medical teams. The FS will develop and periodically review the medical portion of the unit's pre-accident plan as described in AR 385-10, AR 40-21, and DA PAM 385–90. AR 40-21, para 3c. Flight surgeon. The flight surgeon assigned to an aircraft accident investigation board (AR 385–40) will— (1) Make a thorough investigation of the accident, including the medical, psychic, social, economic, and training history of the individuals involved, to discover which factors may have contributed to the accident. (2) Make a thorough investigation of the fatal and nonfatal injuries sustained to determine their causes and to recommend ways of preventing or minimizing recurrence. (3) Correlate the factors causing accident and injury with safety aspects of aircraft design, restraint system design, personal equipment, and existing operational and safety regulations practices, and conditions with other members of the aircraft accident investigation board. (4) Evaluate life support and personal protective equipment which is in any manner implicated in the cause or prevention of injury. Insure that such equipment is forwarded with all components by the accident investigation board president to the Commander, US Army Aeromedical Research Laboratory, P.O. Box 577, Ft. Rucker, AL 36362.

EVAL METH:

Check for updated phone numbers in the Pre-Accident Plan. Flight Surgeon On-Call phone numbers, on and off-airfield medical and ambulance facility phone numbers. Check flight surgeon involvement in developing and periodic review of the medical portion pre-accident plan. Check secondary crash alarm portion to ensure pre-accident plan addresses the duties and responsibilities of the flight surgeon or their assistant. Check flight surgeon responsibilities in the pre-accident plan are clearly identified. Validate flight surgeon participation and review of the plan. Pre-accident plans will be systematically rehearsed and reviewed for adequacy quarterly (at a minimum) and a mishap exercise requiring all elements to physically respond annually. Check Flt Ops Logs, MFRs, AARs, Accident Reports, or FAA reports for Flight Surgeon participation.

18.00 **AC AF AS BN DE OS SB**

Is the supporting flight surgeon or aeromedical physician assistant a member of the Safety Council? [DA PAM 385-90, para 2-4b(7)]

REFERENCE TEXT

DA PAM 385-90, para 2–4b (7). Safety councils and meetings: Safety councils and meetings provide risk management forums to assist the commander in developing and implementing an aviation accident prevention program. Safety councils are named at two levels, the CSC and the ESC. a. Commanders should designate, in writing, safety councils to provide risk-management forums that allow leaders to review current or projected hazards, their associated risk, and to make decisions on their elimination or control. Councils will convene a minimum of quarterly regardless of unit status or location. b. The CSC is organized by the ASO, chaired by the commander, and consists of the following unit personnel (if assigned), at a minimum: (1) Commander. (2) Operations officer (S–3). (4) ASO. (5) Aviation maintenance officer. (6) Aviation Life Support Systems (ALSS) manager. (7) Flight surgeon. (8) Senior unit NCO (1SG/CSM). (9) Aviation safety NCO (ASNCO). (10) Other personnel designated by the commander.

EVAL METH:
Check council appointments and flight surgeon participation in the safety council meetings. Participation is verified by ensuring that the FS was present at the council meeting or by reviewing documentation showing that the FS reviewed council minutes. Check with ARMS Safety Inspector for final results.

19.00 **AC AF AS BN DE OS SB SF**
Does the supporting flight surgeon or aeromedical physician assistant take part in safety meetings and training? [DA PAM 385-90, para 1-4p(12); AR 40-3, para 3-6f (2)]
REFERENCE TEXT
DA PAM 385-90, para 1-4p(12). Flight surgeon. The flight surgeon assists and advises the command in all aviation medical matters. In remote areas where a flight surgeon is not assigned or readily available, local support will be provided by the servicing medical department activity (MEDDAC) to best accomplish these duties. The flight surgeon should (12) Take part in aviation safety meetings to educate aviation crewmembers on the aeromedical aspects of flight. AR 40-3, para 3-6f (2) Conduct aeromedical briefings held for both officer and enlisted personnel at unit-level training or aviation safety meetings.
EVAL METH:
Check training documentation for flight surgeon participation. Participation in training includes attendance and training conducted by the FS at the safety training events. Participation in safety meeting includes documentation showing the FS present at the meeting or review of the meeting minutes.

20.00 **AC AF AS BN DE OS SB SF**
Are aviation accident prevention surveys (AAPS) completed in the area of aviation medicine and keep them on file? [AR 385-10, para 15-3]
REFERENCE TEXT
15–3. Aviation Accident Prevention Surveys All Active Army aviation units and USAR aviation support facilities will conduct Aviation Accident Prevention Surveys semiannually, at a minimum. All other units, including Army Headquarters and Direct Reporting Units, will conduct Aviation Accident Prevention Surveys annually, at a minimum. The "Guide to Aviation Resource Management for Aircraft Mishap Prevention" or a similar guide should be used as a reference. When possible, the Aviation Accident Prevention Surveys should be administered from the battalion/squadron level consolidating the safety staff into asurvey team and using supplemental expertise from outside the unit.

EVAL METH:
Review AAPS documentation from the last five years. Ensure that Aviation Medicine was surveyed and documented at least semi-annually (Active Component) or annually (Reserve Component) in each of the last five years. Pervious ARMS and AAPS conducted with the ARMS Guide (Techniques) Aviation Medicine Checklist are acceptable forms of documentation of pervious AAPS for the functional area of Aviation Medicine. Coordinate with ARMS Safety Inspector if available to determine overall results. If unit does not have an assigned Flight Surgeon/Aeromedical Physician Assistant the unit Safety Officer completes the AAPS. Discuss further with safety evaluator.

21.00 **AC AF AS AT BN DE OS SB SF**
Are hazards found during the AAPS, in the area of aviation medicine, listed on the unit's hazard-tracking system? [DA PAM 385-90, para 2-11]
REFERENCE TEXT
DA PAM 385-90, para 2–11. Aviation accident prevention survey. Commanders of all units should conduct Aviation accident prevention survey (AAPS) annually. This may be conducted in concert with the annual Standard Army Safety and Occupational Health Safety Inspection (SASOHSI) "Guide to Aviation Resource Management for Aircraft Mishap Prevention" or a similar guide should be used as a reference. When possible, the AAPS should be administered from the battalion/squadron level consolidating the safety staff into a survey team and using supplemental expertise from outside the unit. Surveys conducted by external sources (brigade, installation, or Army Headquarters aviation resource management surveys; standard Army safety and occupational health inspections; regional accident prevention surveys) may count toward semiannual accident-prevention surveys, provided all applicable functional areas for the organization are surveyed. An external survey may count toward the annual requirement for Reserve component units. The AAPS may be concurrent with internal command inspection programs as long as all unit functional areas are surveyed. The AAPS is a major source in the hazard identification step of the CRM process. All hazards identified during the AAPS must be thoroughly assessed for their risk level, and control options must be developed for command decision-making and implementation. Hazards found during the AAPS will be tracked through the unit hazard tracking system. Files on subordinate unit surveys may be maintained at battalion/squadron level if the subordinate unit commander has immediate access to the files for control option follow-up and research purposes.
EVAL METH:
Verify that AAPS discrepancies, noted in the area of Aviation Medicine during the last five years, are incorporated into the unit's hazard tracking system. Coordinate with ARMS Safety Inspector if available to determine overall results. If unit does not have an assigned Flight Surgeon/Aeromedical Physician Assistant and unit Safety Officer completes the AAPS / Hazards Log satisfactory, ARMS evaluator may allow a satisfactory rating after further discussion and concurrence with Safety Evaluator.

22.00 **AC AF AS BN DE OS SB SF**
Does the flight surgeon or aeromedical physician assistant assist the unit Aircrew Life Support Equipment shop with Class VIII support and survival education? [AR 95-1, para 8-1g; AR 40-3, para 3-5b(3)]
REFERENCE TEXT
AR 95-1, Para 8-1g. Flight surgeons and aeromedical advisors are responsible for (1) Physiological training of aircrew personnel and (2) medical aspects of survival training of

aircrew personnel. (3) Monitoring the fitting and use of ALSE by aircrew personnel. AR 40-3, para 3-5b (3) Assist unit aircrew life support equipment shop with Class VIII support and survival education.

EVAL METH:

Check for evidence that the flight surgeon has visited the ALSE Shop and assisted in training requirements and class VIII support.

23.00 **AC AS BN DE OS SB SF**

Does the unit's aeromedical training program comply with the following references? [AR 95-1, para 4-13, 8-1g; DA Pam 385-90, para 1-4p(9),(11), (12), (13); TC 3-04.93, para 1-10, 1-11, 1-12, 1-13]

REFERENCE TEXT

AR 95-1, para 4-13 Flight crewmembers will receive aeromedical and low pressure/high altitude training per TC 1–210 and FM 3–04.301. AR 95-1, para 8-1g. Flight surgeons and aeromedical advisors are responsible for—(1) Physiological training of aircrew personnel. (2) Medical aspects of survival training of aircrew personnel. (3) Monitoring the fitting and use of ALSE by aircrew personnel. DA PA 385-90, 1-4p(9), (11), (12), (13). The flight surgeon assists and advises the command in all aviation medical matters. In remote areas where a flight surgeon is not assigned or readily available, local support will be provided by the servicing medical department activity (MEDDAC) to best accomplish these duties. The flight surgeon should (9) Monitor the survival and physiological training of aviation crewmembers and provide medical support in accordance with applicable Army regulations. (11) Make recommendations to the Commander, USACRC, for improvement of human factors compatibility, crashworthiness, aviation life-support equipment, and survival features of aircraft. (12) Take part in aviation safety meetings to educate aviation crewmembers on the aeromedical aspects of flight. (13) Monitor the aviation life support equipment (ALSE) program. TC 3-04.93 para 1-10, CONTINUATION TRAINING. The requirement for continuation training applies to all Army crewmembers in operational flying positions. The POI must be conducted once a year. The following subjects provide the minimum training necessary for the unit to reach adequate safety and efficiency in an aviation environment: altitude physiology, spatial disorientation (SD), aviation protective equipment, stress, fatigue and exogenous factors. TC 3-04.93, para 1-11, MISSION CONSIDERATIONS. The unit commander must evaluate the unit's missions to incorporate mission considerations into the aeromedical training POI. This analysis should include- Combat mission. Installation support missions. Contingency missions. Geographic and climatic considerations Programmed training activities. TC 3-04.93, para 1-12. The supporting flight surgeon will help identify the aeromedical factors present during the various flight conditions and their effect on aircrew performance. The flight surgeon and the unit commander will then develop a POI that meets the unit's specific needs. TC 3-04.93, para 1-13. The commander must include all crew members in the unit aeromedical training program. Individual crewmembers will be evaluated on their aeromedical knowledge during the Annual Proficiency and Readiness Test (APART) period in accordance with the appropriate aircrew training manual (ATM). Lesson materials can be obtained at http://usasam.amedd.army.mil.

EVAL METH:

Check to ensure appropriate aeromedical training is conducted in the organization by verifying sign-in rosters, training schedules, lesson plans, memorandums for record, IATFs and SOPs. Check to ensure that the unit has an effective make up training program.

24.00 **AC AF AS BN DE OS SB SF**

Has a mission analysis been conducted to determine special aeromedical training requirements? [TC 3-04.93, para 1-11]

REFERENCE TEXT

TC 3-04.93, para 1-11. The unit commander must evaluate the unit's missions to incorporate mission considerations into the aeromedical training POI. This analysis should include- Combat mission. Installation support missions. Contingency missions. Geographic and climatic considerations. Programmed training activities.

EVAL METH:

Check for documentation indicating a mission analysis has been conducted to determine training requirements. Documentation includes, but is not limited to, memorandums for record, meeting minutes, proof of aeromedical training planned or conducted that is not specifically required by regulation or training circular. Does the Flight Surgeon/APA participate in long range planning with the Battalion S-3?

25.00 **AC AF AS BN DE OS SB SF**

Do fixed or rotary-wing crew members who fly in pressurized aircraft, or in aircraft that routinely exceed 10,000 feet (MSL) receive hypobaric training? [TC 3-04.93, para 1-3, 1-4, 1-5]

REFERENCE TEXT

TC 3-04.93, para 1-3. Fixed- or rotary-wing crewmembers who fly in pressurized aircraft or in aircraft that routinely exceed 10,000 feet mean sea level (MSL) must complete aeromedical refresher training every 5 years. Crewmembers are required to participate in a hypobaric (low pressure/high altitude) chamber exercise or a reduced oxygen breathing device (ROBD) exercise using the appropriate profile for the aircraft and mission requirements (see appendix A). Crewmembers who fly in pressurized aircraft also must complete a rapid decompression. Training will be conducted by an approved physiological training unit for crewmembers meeting these criteria, with the exception of personnel specified in paragraph 1-4. TC 3-04.93, para 1-4. Crewmembers with 240 months total operational flying duty credit (TOFDC) and four successful altitude chamber iterations must complete classroom training requirements but are exempt from the altitude chamber and rapid decompression practical exercise requirements. Department of the Army civilians (DACs) and contractors with documentation of prior Department of Defense-approved training may, upon approval from the Government flight representative, request exceptions through the

unit standardization section. (DACs and contractors are required to complete annual altitude physiology training requirements.) All crewmembers who meet these requirements and provide the unit standardization section with documented proof of training may receive altitude physiology review classroom training at the unit level. See paragraph 1-20 for Department of the Army (DA) Form 759 (Individual Flight Record and Flight Certificate-Army) requirements. TC 3-04.93, para 1-5. Refresher training consists of classroom instruction to review the essential materials presented in initial training. The minimum refresher training needed to meet the requirements of paragraph 1-3 are: Altitude physiology review. Altitude chamber orientation. Altitude chamber practical exercise. Rapid decompression practical exercise.

EVAL METH:

Verify unit mission profile and equipment to determine if altitude training is required. Check applicable records for the required training certificates.

26.00 **AC** **BN** **DE** **SB**

Have all MOS 68W completed a annual train-up of all critical tasks associated with Medical Education and Demonstration of Individual Competence (MEDIC) by completing Training Tables I through VII and the successful completion of Table VIII (Validation) of MEDIC? (MOS 68W ONLY) [TC 8-800, para,2-1b,k]

REFERENCE TEXT

TC 8-800, para2-1b. TC 8-800 supports or supplements the unit training of Soldier Medics. It provides seven training tables with the associated training support packages (TSP) that have CE and refresher course credit that can be used for NREMT-B recertification. When the tasks in the training tables are trained to standard by a qualified 68W NCO or medical officer, and the training is documented by a medical officer, Soldier Medics meet the CE and biannual refresher course requirements for NREMT-B recertification. As previously stated, CE units are awarded for completion of the training in Tables I through VII, not simply completing the testing in Table VIII. TC 8-800, para2-1k. When Soldier Medics have completed a train-up of all critical tasks associated with Training Tables I through VII and have performed skills to standard, commanders should conduct Table VIII, ACMS-VT. All Soldier Medics in grades E7 and below, regardless of transition status must take and pass the ACMS-VT by demonstrating proficiency on each skill. The validating official will ensure that each Soldier Medic has completed all tasks and annotate the results on DA Form 7442-R [Tracking Sheet – (Table VIII)]. Only individuals who successfully pass all tasks in Table VIII will be reported in MODS.

EVAL METH:

Check 68W training folder for completion of Tables I-VII training on the DA Form 7440-R , skill sheets DA Form 7595-R- 7595-37-R, and DA Form 7442-R Tracking Sheet Table VIII). Ensure recorded events are at least 6 months apart. Verify skills readiness of 68W in Medical Operational Data System (MODS) Recommend advising command to add requirement to the Brigade/Battalion Command Training Guidance in order to identify time and resources on the training calendar and schedule.

27.00 **AC** **BN** **DE** **SB**

Are all 68W military occupational specialty (MOS) recertifying in accordance with National Registry of Emergency Medical Technicians guidance? [AR 40-68, para 4-3a(2),(a),(b)]

REFERENCE TEXT

(2) In specialties that are not licensed by the State, and the requirements of the granting authority for State registration or certification are highly variable, there must be validation by a national organization that the individual is professionally qualified to provide health care in a specified discipline. Examples of this are the National Commission on the Certification of Physicians Assistants (NCCPA) for physician assistants (PAs) and the National Registry of Emergency Medical Technicians (NREMT) for emergency medical technicians. (a) Soldiers (AA/USAR/ARNG) possessing the 91W military occupational specialty (MOS) are required to obtain and maintain certification by the NREMT. Certification will be, at a minimum, at the basic level (emergency medical technician-basic). AA 91Ws will be NREMT certified and meet all other requirements for the MOS by 30 September 2007 (USAR/ARNG soldiers by 30 September 2009). Periodic recertification as established by the NREMT is mandatory. Soldiers who fail to recertify according to NREMT guidance will immediately be suspended from all duties requiring NREMT-basic certification. (b) Soldiers who fail to recertify according to NREMT guidance will be granted an additional 90 calendar days (for AA) and 180 calendar days (for USAR/ARNG) to obtain NREMT-basic certification; soldiers will be deemed MOS qualified during this period. A soldier's failure to obtain NREMT certification immediately following the respective 90- or 180-day period will result in his/her classification as non-MOS qualified and the initiation of an appropriate personnel action (that is, mandatory reclassification, separation) according to governing regulations.

EVAL METH:

Check for NREMT certification on all assigned 68Ws. This can be verified using certification documents or using MODS.

28.00 **AC** **DE**

Are air medical crews of air ambulance units accurately reported on the Unit Status Report (USR) (MEDEVAC only)? [AR 220-1,para 7-8]

REFERENCE TEXT

AR220-1,para 7-8 a.Training days. When determining the number of training days required to become fully trained in core tasks (T–Days, para 7–4), the commander considers and reports the qualification status of unit squads/crews/teams/systems. (1) Reporting units. All AC and RC MTOE and TDA units will report squad/crew/team/system manning and qualification data if they are either required to man any of the elements listed in table 7–5 (that is, squads, crews, or teams) or are equipped with any of the weapons systems listed in table 7–5 or in PC–ASORTS. APS will not report this data. (2) Report consolidation. All FF-level units are required to consolidate and report, within their Type I composite USR, squad/crew/team/system manning and qualification data reported by subordinate units/elements. (3) Additional reported data. The responsible ACOM/ASCC/DRU and/or DARNG/NGB, when applicable, and composite reporting units (FF-level UICs) may direct subordinate units/elements to report manning and qualification data for additional MTOE/TDA squads/crews/teams/systems in the USR. b. Reported data. Units report manning and qualification data for squads/crews/team/systems on the PC-ASORTS menu screen for squad/crew/team/system status data. See example at figure 7–6.

EVAL METH:
Check the unit status report for accurate reporting of air medical crews. Verify accuracy by reviewing Unit Manning Roster, MTOE, TDA, IATF RL level, Training recorded in MODS. Ensure reporting is accurate by reviewing the USR.

29.00 **AC** **BN** **DE**
Has the command surgeon (flight surgeon) established, in writing, a set of local medical treatment protocols for air ambulance personnel (Flight Medics) (MEDEVAC only)? [AR 40-3, para 3-6d; FM 4-02, 3-2c; TC 1-237, task 2120]
REFERENCE TEXT
AR 40-3, para 3-6d Air ambulance operations. The FS will—(1)Function as medical technical advisor to local air ambulance unit commanders and MTF commanders. This includes, but is not limited to, instructing medical evacuation personnel, reviewing reports of medical evacuations (run sheets) for appropriateness of the mission and the care given, and evaluating equipment taken aboard medical evacuation aircraft. (2) Participate in actual air evacuation missions as appropriate. FM 4-02, 3-2c. The duties and responsibilities of command surgeons may include, but are not limited to—Developing policies, protocols, and procedures pertaining to the medical and dental treatment of sick, injured, and wounded personnel. These policies, protocols, and procedures will be in consonance with applicable regulations, directives, and instructions; higher headquarters policies; standing operating procedures (SOPs); applicable STANAGs and QSTAGs; memorandums of understanding (MOU) or agreement (MOA); Status of Forces Agreements (SOFAs); and the DEPMEDS Administrative Procedures, Clinical and Support Guidelines, and Patient Treatment Briefs (Appendix A). TC 1-237, Task 2120 CONDITIONS: In a medical evacuation (MEDEVAC) configured H-60 helicopter, given a medical equipment set (air ambulance), with an actual or simulated patient(s), additional equipment according to local medical treatment protocols. DESCRIPTION: 1. Patient contact. a. Perform triage as necessary and treat injuries and illnesses per local medical treatment protocols in accordance with TC 8-800 (MEDIC) and STP 8-91W15-SM-TG.
EVAL METH:
The evaluator will check the air ambulance unit's for current required local medical treatment protocols.

30.00 **AC** **BN** **DE**
Does a flight surgeon and or the aeromedical physician assistant participate in the medical training air ambulance personnel (MEDEVAC only)? [AR 40-3, paras 3-6d; 13-3c(4)]
REFERENCE TEXT
AR 40-3, para 3-6d. Air ambulance operations. The FS will—(1) Function as medical technical advisor to local air ambulance unit commanders and MTF commanders. This includes, but is not limited to, instructing medical evacuation personnel, reviewing reports of medical evacuations (run sheets) for appropriateness of the mission and the care given, and evaluating equipment taken aboard medical evacuation aircraft. (2) Participate in actual air evacuation missions as appropriate. AR 40-3, para 13-3c(4) Training of emergency medical technician (EMT) personnel shall be according to the Department of Transportation EMT National Standard Curriculum or equivalent to it and accepted by the National Registry for Emergency Medical Technicians (NREMT). EMTs working in pre-hospital EMS, to include both ground and air ambulance, shall possess and maintain current certification through the NREMT commensurate with the requirements of the positions to which currently assigned(that is, emergency medical technician-basic (EMT–B), emergency medical technician intermediate (EMT–I), emergency medical technician-paramedic (EMT–P)).
EVAL METH:
Check for evidence of flight surgeon participation in the required training.

31.00 **AC** **BN** **DE**
Does the flight surgeon or the aeromedical physician assistant review reports of medical evacuations (run sheets) for appropriateness of the mission and care given (MEDEVAC only)? [AR 40-3, para 3-6d]
REFERENCE TEXT
AR 40-3, para 3-6d. Air ambulance operations. The FS will—(1) Function as medical technical advisor to local air ambulance unit commanders and MTF commanders. This includes, but is not limited to, instructing medical evacuation personnel, reviewing reports of medical evacuations (run sheets) for appropriateness of the mission and the care given, and evaluating equipment taken aboard medical evacuation aircraft. (2) Participate in actual air evacuation missions as appropriate.
EVAL METH:
Check for review of the run sheets.

32.00 **AC** **BN** **DE**
Is the FS/APA familiar with and ensure airworthiness releases have been issued for all medical equipment taken aboard medical evacuation aircraft (MEDEVAC only) ? [AR 40-3, para 3-6d]
REFERENCE TEXT
AR 40-3, para 3-6d. Air ambulance operations. The FS will— (1) Function as medical technical advisor to local air ambulance unit commanders and MTF commanders. This includes, but is not limited to, instructing medical evacuation personnel, reviewing reports of medical evacuations (run sheets) for appropriateness of the mission and the care given, and evaluating equipment taken aboard medical evacuation aircraft. (2) Participate in actual air evacuation missions as appropriate.

EVAL METH:
Check for evidence of the FS/APA's familiarity with medical equipment taken on board unit aircraft. Does the FS/APA maintain copies of air worthiness releases for all medical equipment taken on board the unit's air ambulance.

33.00 **AC** **BN** **DE**
Are medical equipment sets, kits, outfits, and tools (SKOT) for air ambulance operations accurately reported on the Unit Status Report (MEDEVAC only)? [AR 220-1, para 5-5]
REFERENCE TEXT
AR 220-1, para 5-5. Evaluating component part availability. a. Reportable LINs having several components, for example, sets, kits or outfits (SKO) and/or medical materiel equipment sets (MMS/MES/DES/DMS/VES), will be reported as on hand if property records show the LIN has been issued and at least 90 percent of each SKO nonexpendable and durable items are present and serviceable. Do not count the set as on hand, if more than 10 percent of the nonexpendable and/or durable components are unserviceable, missing, depleted, or require supply action under AR 735-5 (for example, a report of a survey). b. ALL RC units will exclude all expendable and durable MMS/MES/DES/DMS/VES component items that have a shelf life less than 60 months (shelf life codes of A-H, J-M, P-R, or 1-9). AC, echelon III and IV medical units will exclude all expendable and durable items with a shelf life less than 60 months that are part of the Surgeon General's centralized contingency programs. The list of this materiel is available in SB-8-75-S7 and can be accessed on http://www.usamma.army.mil/.
EVAL METH:
Check the unit status report for accurate reporting of medical equipment sets, kits, outfits and tools. Verify shortages by reviewing property book, hand receipt and turn in documents. If necessary, verify shortages by physical inspection. If component shortages of greater than 90% exist, review the USR for proper reporting.

34.00 **AC** **BN** **DE**
Are medical equipment sets, kits, outfits, and tools (SKOT) shortages identified and on a valid requisition (MEDEVAC only)? [AR 710-2, para 2-6]
REFERENCE TEXT
AR 710-2, para 2–6. Requesting supplies a. Commanders will ensure that equipment and components listed in the authorized column (of the MTOE and TDA) are on hand or on request. Where available, TAADS-based automated systems such as: Distribution Execution System (DES), Logistics Army authorization document system (LOGTAADS), SPBS–R, DPAS, and the SPBS–R/I TDA will be used to request MTOE/TDA items. For an ammunition basic load requested on a preapproved DA Form 581 (Request For Issue and Turn-In of Ammunition), but not on hand, the document number will be entered to the property book.
EVAL METH:
Verify shortages by reviewing property book, hand receipt, shortage annexes and turn in documents. If necessary, verify shortages by physical inspection. Check for the requisitions and check with the ARMS team supply for their results of the unit supply evaluations.

B-CLINICAL DUTIES

QUESTION
1.00 **AC AF AS AT BN DE SB SF**
Are individual Health Records in the custody of a medical treatment facility or maintained by an appointed Health Record Custodian? [AR 40-66, para 1-6]
REFERENCE TEXT
1–6. Record ownership. a. Army medical records are the property of the Government. Thus, the same controls that apply to other Government documents apply to Army medical records. (See DODI 6040.43, AR 25–55, AR 25–400–2, and AR 340–21 for policies and procedures governing the maintenance and release of Government documents.) b. Army medical records, other than those of RCs, will remain in the custody of the MTFs at all times. RC records will remain in the custody of the appointed STR custodian. The AHLTA medical record will remain in the custody of the AMEDD and DOD via electronic storage, and a hard copy of the ITR and OTR will be retired to the NPRC in accordance with the records disposition schedule in AR 25-400-2. A copy of the STR (including dental record) will be retired to the Veterans Affairs Records Center. This medical record is the Government's record of the medical care that it has rendered and must be protected. The patient will not transport the STR, OTR, or CEMR. Upon request, the patient may be provided with a copy of his or her record, but not the original record. Only one free copy may be provided to the patient. Procedures should ensure conscientious Government control over medical records for good medical care, performance improvement, and risk management. Limit access to all open record storage areas and to electronic records to authorized personnel only. Only authorized personnel will have access to all open record storage areas and to electronic records. (The National Archives and Records Administration sets the standards for records facilities and their fire protection (36CFR1228K at http://archives.gov/about/regulations/part-1228/k.html).
EVAL METH:
Check record custody procedures. In the case of RC units maintaining their Medical Records, ensure that the custodian is appointed on orders by the commander.

2.00 **AC AF AS AT BN DE SB SF**
Is the Health Records custodian appointed and trained in accordance with HIPAA/PHI? [AR 40-66, para 2-2e]
REFERENCE TEXT
AR 40-66, para 2-2e. PHI is often viewed by clerical and administrative personnel, such as secretaries, transcriptionists, and medical specialists. This access is authorized and

necessary in order for an MTF to properly process and maintain information and records. However, the MTF commander will ensure that all persons with access to PHI are trained in their obligation to maintain the confidentiality and privacy of PHI. Required training includes web-based program modules covering health information privacy laws and procedures for using or disclosing PHI.

EVAL METH:

Verify medical record custodian(s) is/are trained in HIPPA website https://aamaweb.usaama.rucker.amedd.army.mil/AAMAWeb/HIPAA_Training_static.htm.

3.00 **AC AF AS AT BN DE SB SF**

Are individual Health Records physically stored to ensure security and confidentiality of the records? [AR 340-21, para 4-4; AR 40-66, para 2-2e]

REFERENCE TEXT

AR 340-21, 4–4. Safeguarding personal information a. The Privacy Act requires establishment of proper administrative, technical, and physical safeguards to—(1) Ensure the security and confidentiality of records. (2) Protect against any threats or hazards to the subject's security or integrity that could result in substantial harm, embarrassment, inconvenience, or unfairness. b. At each location, and for each system of records, an official will be designated to safeguard the information in that system. Consideration must be given to such items as sensitivity of the data need for accuracy and reliability in operations, general security of the area, and cost of safeguards. (See AR 380–380.) c. Ordinarily, personal information must be afforded at least the protection required for information designated "For Official Use Only."(See AR340–17, chap IV.) Privacy Act data will be afforded reasonable safeguards to prevent inadvertent or unauthorized disclosure of record content during processing, storage, transmission, and disposal. AR 40-66, 2-2e. PHI is often viewed by clerical and administrative personnel, such as secretaries, transcriptionists, and medical specialists. This access is authorized and necessary in order for an MTF to properly process and maintain information and records. However, the MTF commander will ensure that all persons with access to PHI are trained in their obligation to maintain the confidentiality and privacy of PHI. Required training includes web-based program modules covering health information privacy laws and procedures for using or disclosing PHI.

EVAL METH:

Check security of health records. In the case of RC units maintaining their Medical Records, ensure that only authorized personnel have physical access to the records.

4.00 **AC AF AS AT BN DE SB SF**

Is access to individual Health Records restricted to authorized personnel only? [AR 40-66, para 5-23]

REFERENCE TEXT

AR 40-66, para 5–23. Access to health records All personnel having access to HRECs will protect the privacy of PHI. (See chap 2.) The extent of access allowed to certain personnel is described in a through e, below. a. Medical personnel. AMEDD personnel are allowed direct access to HRECs for purposes of diagnosis, treatment, and the prevention of medical and dental conditions. They also have access to work for the health of a command and to do medical research. b. Military members. If a military member requests information from his or her HREC or copies of the documents in it, it will be given to him or her. If the record is a special category record, see AR 340–21, paragraph 2–5. However, the failure or refusal of a patient to designate a physician to receive information from his or her health record does not relieve the Army of the obligation to eventually provide the requested information to the patient. In this circumstance, competent medical authority will institute and adhere to appropriate procedures to ensure that the actual or perceived harm to the patient by disclosure of the health record is minimized. c. Inspectors. Personnel inspecting MTF, DENTAC, or USAR records are allowed direct access to HRECs. These personnel include Inspector General personnel conducting Nuclear Surety Program and Chemical Surety Program inspections in accordance with AR 50–5 and AR 50–6 (AR 20–1); it also includes Defense Nuclear Agency inspectors conducting Defense Nuclear Surety Inspections in accordance with AR 50–5. Inspectors may have access to HRECs to evaluate the compliance of AMEDD personnel with regulations. All inspectors must respect the confidentiality of the HRECs they inspect. Inspectors do not have unlimited access to ASAP–OMRs in accordance with 42 USC 290dd–2. d. Mortuary affairs personnel. Mortuary affairs personnel are allowed direct access to the HRECs of personnel killed or missing in action. They may have access to extract medical and dental information needed by their service. e. Other nonmedical Army personnel. Nonmedical personnel may need information from a person's HREC for official reasons. These personnel include unit commanders; inspectors general; officers, civilian attorneys, and military and civilian personnel of the Judge Advocate General's Corps; military personnel officers; and members of the U.S. Army Criminal Investigation Command or military police performing official investigations. Official requests for specific information from the HREC or copies of documents in it will be sent to the MTF Patient Administration Division, DENTAC commander, or RC record custodian, who will determine what information will be supplied by the MTF. (See para 2–3a.) Persons designated as certifying and reviewing officials in accordance with the terms of the Personnel Reliability Program, in accordance with AR 50–5 and AR 50–6, are authorized to review medical records of candidates and members of the Personnel Reliability Program in conjunction with proper medical authorities. Access to ASAP–OMRs is limited. (See guidance in 42 USC 290dd–2.)

EVAL METH:

Check for restricted access to health records. In the case of RC units maintaining their Health Records, ensure that an access roster is signed by the commander and posted. Access must be limited to those authorized in AR 40-66, para 5-23e.

5.00 **AC AF AS AT BN DE SB SF**

Does the unit commander ensure confidentiality of individual Health Records and patient medical information? [AR 40-66, para 2-2]

REFERENCE TEXT

AR 40-66, para 2–2. Policies governing protected health information; DA policy mandates that the confidentiality of PHI of both living and deceased individuals will be ensured to the fullest extent possible. PHI will be disclosed only if authorized by law and regulation. a. Within DA, PHI may be used for treatment, payment, health care operations, and preventive care of patients. PHI may also be used within DA to monitor the delivery of health–care services, to conduct medical research, to provide medical education, to facilitate

hospital accreditation, and to satisfy other official purposes. b. Each Army MTF/DTF will give patients a copy of the Notice of Privacy Practices (NOPP). The NOPP explains to beneficiaries how their PHI may be used as well as their patient rights concerning PHI. Beneficiaries will sign the NOPP acknowledgment (para 4–4) showing that they received this notice. Note: A military prison inmate does not complete the NOPP acknowledgment. c. Unless authorized by law or regulation, no person or organization will be granted access to PHI. d. Any person who, without proper authorization, discloses PHI may be subject to adverse administrative action or disciplinary proceedings. Under HIPAA, penalties for misuse or misappropriation of PHI include both civil monetary penalties and criminal penalties. Civil penalties range from $100 for each violation to a maximum of $25,000 per year for the same violations. Criminal penalties vary from $50,000 and/or 1–year imprisonment to $250,000 and/or 10–years imprisonment (Sections 1320d–5 and 1320d–6, Title 42, United States Code). Report all possible violations of this regulation to the Privacy Officer and/or the commander, who will consult with the servicing legal office to determine a proper disposition for the reported violation. e. PHI is often viewed by clerical and administrative personnel, such as secretaries, transcriptionists, and medical specialists. This access is authorized and necessary in order for an MTF to properly process and maintain information and records. However, the MTF commander will ensure that all persons with access to PHI are trained in their obligation to maintain the confidentiality and privacy of PHI. Required training includes web–based program modules covering health information privacy laws and procedures for using or disclosing PHI.

EVAL METH:

Check local procedures to ensure confidentiality.

6.00 **AC AF AS AT BN DE SB**

For Active Duty units, are Health Record files screened semi-annually against current personnel rosters? [AR 40-66, para 5-29b(3)]

REFERENCE TEXT

AR 40-66, para 5-29b (3) STR files for active duty personnel will be screened semiannually against current personnel rosters to ensure that the MTF file holds only the records of personnel served by that MTF. When an STR or medical form is held by the wrong custodian, MTF records personnel will send the documents to the current custodian.

EVAL METH:

Check for the screening procedures. Verify that last screening was completed not more than six months previous.

7.00 **AC AF AS AT BN DE SB SF**

Do the flight surgeon and or aeromedical physician assistant have access to health records at time when health care is delivered or flight physical is conducted? [AR 40-3, para 3-5a(5); AR 40-501, para6-10a]

REFERENCE TEXT

40-3, para 3-5a(5) Flight Surgeon clinical duties. (5) Review care provided by other health care providers for impact on the flight status of aviation personnel. AR 40-501, para6-10a Disposition and review of FDMEs a. Review. The review of the individual health record and FDME/FDHS will be completed by the aeromedical health care provider. The aeromedical health care provider will counsel the examinee regarding—(1) Conditions found during the FDME. (2) Continuing care for conditions under treatment and/or waiver. (3) General preventive health education, including, but not limited to smoking, cholesterol control, weight control, drug and alcohol abuse, and other high risk behavior.

EVAL METH:

Have flight surgeon explain clinical duties/process in regards to reviewing air crewmember medical records during flight physical.

8.00 **AC AF AS AT BN DE SB SF**

Do the flight surgeon and or aeromedical physician assistant ensure that the health records of aviation personnel are maintained appropriately, and are all required DA Forms 4186 properly completed? [AR 40-3, para 3-5a(2); AR 40-66, para 5-21b(6); AR 40-501, para 6-11d; ATB: DA4186 Usage, page 44]

REFERENCE TEXT

Para. 3–5a (2). Flight surgeon clinical duties. a. Primary care. The FS will— (2) Ensure appropriate maintenance of medical records on all aviation personnel, including air crewmembers in non-operational assignments even if not on active flying duty (on flight status). He or she will maintain a tracking mechanism to ensure aeromedical documents such as FDMEs, DA Forms 4186, and so forth, arrive at their proper destinations. He or she will also ensure aviation medical records are included in all supervising MTF health record (HREC) quality assurance programs. AR 40-66, 5-21b(6). (6) DA Form 4186. File the most recent DA Form 4186 or electronic equivalent, according to figures 5-1 and 5-2. Additional DA Forms 4186 will be filed in order according to the guidelines in (a)-(c) below. Destroy other DA Forms4186. Block 8b of DD Form 2766 will be updated in pencil to show the current flying status. When available, the AHLTA application will be used to capture this information. (a) The most recent DA Form 4186 that shows a medical restriction from flying if the person is granted clearance to fly. (b) The most recent DA Forms 4186 showing that a waiver has been granted for any cause of medical unfitness for flying. (c) Any additional DA Form(s) 4186 that the flight surgeon determines to be required as a permanent record. (Enter "Permanent Record" in “Remarks” section.) AR 40-501, 6-11d. Each item of the DA Form 4186 will be completed as directed by the Commander, USAAMC. (See ATB: DA Form 4186 Usage, para5) Three copies of the DA Form 4186 will be completed. Copy 1 is placed in the outpatient medical record. Copy 2 is forwarded to the examinee’s unit commander who signs and forwards it to the flight operations officer for inclusion in the flight records (AR 95–1 and FM 3–04.300). Copy 3 is given to the examinee.

EVAL METH:

Check health records to determine completion and correctness. Verify records are incorporated into a quality assurance program. Check for required DA Forms 4186 and verify the form is filled out properly

9.00 **AC AF AS AT BN DE SB SF**

Does non-aeromedically trained providers issue a DA Form 4186 to return a crewmember to flying duty only when a flight surgeon (FS), aviation physician assistant (APA), aeromedical nurse practitioner (AMNP), or aeromedical examiner (AME) is not readily available, and is the DA Form 4186 properly annotated to confirm the flight surgeon giving the verbal or telephonic approval? [AR 40-501, para 6-11j(3)]

REFERENCE TEXT

AR 40-501,Para 6-11, j. (3) A non-aeromedically trained provider under the supervision of a FS may sign the DA Form 4186 to recommend returning aircrew and ATCs to FFD when a FS is not locally available by obtaining case-by-case telephonic guidance from a FS. The name of the consulted FS will be annotated on DA Form 4186, and on an SF 600 (Health Record—Chronological Record of Medical Care) in the patient health record.

EVAL METH:

In the case of a non-aromedically trained provider issuing a DA Form 4186, ensure that the FS is annotated or cosigns the DA Form 4186 prior to issuance. Also, ensure that the telephonic approval and the Flight Surgeon's name is mentioned in the remarks block of the DA Form 4186, and ensure that an SF 600 is posted in the Health Records noting the telephonic approval. The case by case telephonic approval should only be used when there is no flight surgeon on the installation (leave, TDY, deployment, no flight flight surgeon assigned).

10.00 **AC AF AS AT BN DE SB SF**

Does the flight surgeon and or the aeromedical physician assistant interview newly assigned aviation personnel and review their medical records before granting a medical clearance to fly? [AR 40-3, para 3-5d(2)]

REFERENCE TEXT

AR 40-3, para 3-5d (2) Interview newly assigned aviation personnel and review their medical records before granting a medical clearance to fly.

EVAL METH:

Review the Flight Surgeon's procedures to see if the flight surgeon is interviewing all newly assigned crewmembers and reviewing their Health Records prior to issuing a DA Form 4186.

11.00 **AC AF AS AT BN DE SB SF**

Are Aircrew members informing the flight surgeon or aeromedical physician assistant when they have participated in activities or have received treatment following which there may be flying restrictions, and are these events documented on a DA Form 4186? [AR 40-3, para 3-5d (3); AR 40-8, para 4-b(1-6); AR 40-501, para 6-11b(1-8)]

REFERENCE TEXT

AR 40-3, para 3-5d(3). The flight surgeon will establish procedures whereby air crewmembers are automatically grounded when treated in the emergency department or specialty clinic. Protocols will then require grounded air crewmembers to report to the FS as soon as reasonably possible. AR 40-8, para 4b(1-6). Aircrew members will immediately inform their flight surgeon or APA when they have participated in activities or received treatment for which flying restrictions may be appropriate. This includes exposure to any exogenous factors listed in this regulation as well as any treatment or procedure performed by a non-flight surgeon or APA and includes, but is not limited to, the following:(1) Any medical or dental procedure requiring use of medication after the treatment. (2) Any medical or dental procedure requiring use of any type of anesthesia or sedation. (3) Treatment by mental health professionals, including but not limited to psychological, social, psychiatric, alcohol, or substance abuse counseling. (4) Any chiropractic or osteopathic manipulative treatment. (5) Any treatment given by a homeopath, naturopath, herbalist, or practitioner of other types of alternative medicine. (6) Any emergency room or urgent care visits. AR 40-501 6-11b. DA Form 4186 will be completed—(1) After the completion of an FDME/FDHS. (2) After an aircraft mishap. (3) After an FEB. (4) When reporting to a new duty station or upon being assigned to operational flying duty. (5) When admitted to and discharged from any medical or dental treatment facility (inpatient or outpatient, military or civilian), sick in quarters, interviewed for or entered into a drug/alcohol treatment program, or when treated by a health care professional who is not a military FS/APA/AMNP/AME or otherwise authorized to issue a DA Form 4186. (6) When treated as an outpatient for conditions or with drugs that are disqualifying for aviation duties; and upon return to flight duties after such treatment and recovery. (7) Upon return to flight status after termination of temporary medical suspension, issuance of waiver for aviation service, or requalification after medical or nonmedical termination of aviation service. (8) Other occasions as required by the FS/APA/AMNP/AME.

EVAL METH:

Check for unit procedures to verify that aircrew members are informing the FS. Check Health Records for possible grounding medical conditions and ensure that a DA Form 4186 is used to document informing the FS. Review the flight surgeon's SOP to ensure there are procedures established for automatic grounding and the requirement for all aircrew to see the flight surgeon for and upslip.

12.00 **AC AF AS AT BN DE SB SF**

Does the Flight Surgeon or aeromedical physician assistant medically clear air crewmembers for further flight duty following temporary medical disqualification or after an aircraft mishap? [AR 40-3, para 3-5d(4); AR 40-501, paras 6-11b(2,5,6,7, 8)]

REFERENCE TEXT

AR 40-3., para 3-5d(4) Medically clear air crewmembers for further flight duty following temporary medical disqualification or aircraft mishap. AR 40-501, paragraph 11b. DA Form 4186 will be completed – (2) After an aircraft mishap. (5) When admitted to and discharged from any medical or dental treatment facility (inpatient or outpatient, military or civilian),

sick in quarters, interviewed for or entered into a drug/alcohol treatment program, or when treated by a health care professional who is not a military FS/APA/AMNP/AME or otherwise authorized to issue a DA Form 4186. (6) When treated as an outpatient for conditions or with drugs that are disqualifying for aviation duties; and upon return to flight duties after such treatment and recovery. (7) Upon return to flight status after termination or temporary medical suspension, issuance of waiver for aviation service, or requalification after medical or nonmedical termination of aviation service. (8) Other occasions as required by the FS/APA/AMNP/AME.

EVAL METH:

Check records for DA Forms 4186 showing medical clearance after a temporary medical disqualification or aircraft mishap.

13.00 **AC AF AS AT BN DE SB SF**

Do individual Health Records contain medical waivers and suspension recommendations and approval letters as applicable? [AR 40-501, para 6-10g]

REFERENCE TEXT

AR 40-501, para 6-10g. Disposal of documentation. Waiver and suspension recommendation and approval letters will be filed in the individual health record and flight record. When available, the AERO Abbreviated Waiver Letter shall be utilized for the individual flight record folder (IFRF) for Health Insurance Portability and Accountability Act (HIPAA) compliance of protected health information.

EVAL METH:

Check HREC for applicable waivers and approval letters. Abbreviated waiver approval memorandums are obtained through the AERO.

14.00 **AC AF AS AT BN DE SB SF**

Are sign-out procedures established to maintain accountability of health records? [AR 40-66, para 4-6]

REFERENCE TEXT

4–6. Record chargeout system. a. The current physical location or destination of each record must be known. A chargeout folder will be put in the file when a record is removed for use. The type of folder used may be determined locally; however, DA Form 3444–series or DA Form 8005–series may not be used. (1) OF 23 (Charge–Out Record) or another chargeout record will be put in the folder; this record will show where the medical record is located. If a charged–out record is later moved to another location, a “change–of–charge “must be submitted to the record custodian. (2) Any laboratory reports, x rays, or other reports that arrive while a record is charged out will be put in the folder until the record is returned. (3) Records will be charged out no longer than necessary. Records sent to in–house clinics will be returned the same day as the clinic visit. However, if the record is transferred to another clinic for a consultation the following day, a change–of–charge will be sent to the record custodian instead of the record. b. For health and outpatient records withdrawn from the files and transferred to another MTF, see paragraphs 5–27 and 6–4.

EVAL METH:

Check for established SOP on sign-out procedures.

15.00 **AC AF AS AT BN DE SB SF**

Are procedures established for disposition of health records of personnel no longer assigned? [AR 40-66, para 5-29d(3)]

REFERENCE TEXT

AR 40-66, para 5-29d(3) If the MILPO or post locator cannot find the address of the proper custodians, the MTF or DTF will follow the steps outlined in (a) through (f), below. (a) Rule 1. If the records or forms include a complete name and SSN and are Army records or forms (officers, warrant officers, and enlisted personnel) (based on a check of outprocessing and separation files, the local Standard Installation/Division Personnel System alpha roster, and DEERS) and if the MILPO provides a forwarding active duty address, send the records or forms to the forwarding address. If the member retired or was discharged or separated to an inactive USAR status, send the records or forms to VA Records Center, P.O. Box 5020, St. Louis, MO 63115–8950 VA Records Center, 4300 Goodfellow Blvd., Bldg 104 N, St. Louis, MO 63115-8950. If an address from orders or DD Form 214 (Certificate of Release or Discharge from Active Duty) assigns the member to a USAR troop program unit (TPU) or releases the USAR member from active duty for training or initial active duty for training, send the records or AR 40–66 • 17 June 2008 41 Express, United Parcel Service, or overnight delivery service, send records/forms to VA Records Center, 4300 Goodfellow Blvd., Bldg 104 N, St. Louis, MO 63115-8950. If an address from orders or DD Form 214 releases the ARNGUS member from active duty for training or initial active duty for training, send the records or forms to the appropriate State Adjutant General. If the member has departed on terminal leave but has not reached his or her actual separation date, send the records or forms to the servicing separation transfer point. Another system to locate Soldier’s present duty station is by accessing the Soldier’s name and SSN in the PAD module of the Military Occupational Data System. If no information and no record is available, send a request for locator service, listing the member’s full name and his or her sponsor’s SSN, to the Commander, HRC–Ind, ATTN: AHRC–EF, 8899 East 56th St., Indianapolis, IN 46249–5301. Requests for locator service may also be submitted via facsimile at (317) 510–3685. The Locator Service Office can be contacted at 699–3682 (DSN) or (317) 542–3682, but locator information will not be provided over the phone. Hold the records or forms until receiving a response identifying a disposition address. 1. Rule 1a. If records belong to a member of the USAR and a status and location can not be determined, MTFs will contact the U.S. Army Reserve Command Surgeon at (404) 464-8214/8216. 2. Rule 1b. If records belong to a member of the ARNG and a status and location can not be determined, the record will be forwarded to: SAIC, Suite #250, ATTN: STR, 7125 Columbia Gateway Drive, Columbia, MD 21046. (b) Rule 2. If the records or forms include a complete name and SSN and are Navy records or forms, send them to Naval Military Personnel Command, AT TN: NMPC – 036, Navy World wide Locator Service , Washington , DC 20370–5000. (c) Rule 3. If the records or forms include a complete name and SSN and are Marine Corps records or forms, send them to Commandant of the Marine Corps, Headquarters USMC, Medical Records Unit (MMSB-16) 2008 Elliot Road, Quantico, VA 22134. (d) Rule 4. If the records or forms include a complete name and SSN and are Air Force records or forms, send them to Air Force Medical Operations Agency, AFMOA/SG3SA, 110 Luke Ave., Rm 321, Bolling AFB

DC 20032. (e) Rule 5. If the records or forms include a complete name and SSN and are PHS or Coast Guard commissioned corps records or forms, send them to Medical Branch, 5600 Fishers Ln., Parklawn Bldg., Room 4–35, Rockville, MD 20857–0435. (f) Rule 6. If the records or forms include a complete name and SSN and are National Oceanic and Atmospheric Administration records or forms, send them to Commissioned Personnel Center, NOAA (ATTN: CP01), 11400 Rockville Pike, Room 108, Rockville, MD 20852–3004. e. Handling unidentifiable records and forms. An unidentifiable record or form is one that contains either no data or such a small amount of data that identifying the person to whom it belongs is impossible. (See para 3–7)

EVAL METH:

Check to ensure disposition procedures are established and that no extraneous records are present.

16.00 **AC AF AS AT BN DE SB SF**

Does the flight surgeon or aeromedical physician assistant recommend medical termination from aviation service (permanent medical suspension) if the term of temporary medical suspension has or is expected to exceed 365 days? [AR 40-501, para 6-17a]

REFERENCE TEXT

AR 40-501, para 6-17a. Medical termination from aviation service (permanent medical suspension) is required for permanent aeromedical DQs that are not likely to result in requalification within 365 days. Continuation of flying duties is only authorized by issuance of orders for an aeromedical waiver (para 6–19) by an aviation service waiver authority.

EVAL METH:

Determine if the unit has any crewmembers have been temporarily grounded for over 365 days. Verify that the FS has recommended a permanent medical suspension.

17.00 **AC AF AS AT BN DE SB SF**

Are crewmembers completing FDMEs within 90 days of redeployment if they received incomplete “deployment” FDMEs while deployed? [AR 40-501, para 6-8d]

REFERENCE TEXT

AR 40-501, para 6-8d. The FDME will be completed to the extent the MTFs permit when aircrew are on duty or in mobilization at a station OCONUS with limited military medical facilities. Email or attach a cover letter to the FDME addressed to Commander, USAAMC, ATTN: MCXY-AER (USAAMA), explaining the facility limitations. Accomplish a comprehensive FDME/FDHS within 90 days upon return to a station with adequate medical facilities. Align subsequent Comprehensive or Interim FDMEs with the aircrew member’s birth month using table 6-1.

EVAL METH:

Check records for completion of FDMEs within 90 days of redeployment. Do not confuse the OTSG 120 day FDME extension with this 90 day guidance. The OTSG 120 day FDME is only if a crew member is absolutely unable to conduct an FDME during deployment or if a State is truly unable to provide an aeromedical provider to complete an FDME during the deployment loss of their Flight Surgeon.